REPORT OF THE GOVERNOR'S TASK FORCE ON HEALTH CARE COST CONTAINMENT

Submitted to Governor Harry Hughes
December 14, 1984

State of Maryland

Eugene M. Feinblatt, Chairman

EXECUTIVE SUMMARY

I. Background

The Task Force on Health Care Cost Containment was convened by Governor Hughes in August, 1984, to address the problem of the rapid escalation in health care costs. While the Governor recognized the outstanding record of health cost containment in Maryland, he expressed concern over the impact of continuing health cost increases on both the citizens and the economy of the State.

The rising cost of health care hits hardest among those segments of the population least able to afford needed care - the elderly, the handicapped and disabled, and the economically disadvantaged. Often, these citizens are most in need of health care services, yet they may be forced to forgo needed treatment because of insufficient financial resources. Business and labor in Maryland have also recognized that increasing health care costs reduce business efficiency and productivity, and ultimately reduce the ability of Maryland industry to compete.

In his charge the Governor asked the Task Force to address three major issues. These are 1) the need to strengthen our existing regulatory system, 2) the need to identify and reduce excess capacity in the health care system, and 3) the need to control the rising costs of health insurance to employers and consumers.

The Task Force met since August, for the most part on a weekly basis, to consider not only these issues but a broad range of related issues that effect the escalation in health care costs. The Task Force also heard testimony from a variety of interested parties, and conducted a day of public testimony which was open to any member of the public who wished to express his or her concerns.

II. General Conclusions

In addition to a series of specific recommendations presented later in the report, the Task Force arrived at general conclusions regarding Maryland's health care system that should guide policy-makers in future efforts to contain health care costs. These conclusions were as follows:

- o There are multiple, interrelated factors that cause health care cost increases. Therefore, cost containment should be pursued through a program or package of initiatives that create incentives to reduce costs throughout the entire health care system.
- o Cost containment efforts should not lead to denying Maryland citizens access to necessary care.
- o The effect of proposals to reduce hospital costs should be monitored for their impact on the growth of non-hospital services.
- o Physicians are critical participants in achieving health cost containment, as the practice patterns of physicians determine a significant portion of total health care costs.
- o A cooperative environment has historically existed in the Maryland health care industry. For cost containment to be fully effective, regulators, the regulated industry, employees and insurers must continue to foster that cooperative spirit.
- o Quality of care is and should continue to be of paramount importance in the delivery of health care. Cost containment efforts should never diminish quality of care; and can actually improve quality where inappropriate care is eliminated.
- o Prevention of illness or injury improves the quality of life for all, and can be very effective in constraining health cost increases. Prevention programs should be supported and strengthened.
- o The very successful regulatory system in Maryland should continue and be strengthened where necessary. At the same time, competition that is consistent

with our system-wide goal of access to quality, affordable health care should also be encouraged.

III. Recommendations

In pursuing its charge from the Governor, the Task Force determined that an effective program of health care cost containment must embody four major approaches. These are 1) enhancing existing regulatory authority where needed, 2) controlling the utilization of health care services, 3) modifying insurance incentives, and 4) reducing the excess capacity in beds and services that presently exists in the Maryland hospital system.

The Task Force developed a series of specific recommendations to address each of these concerns. In addition, the Task Force identified a number of issues of importance that could not be adequately addressed in the time available. The Task Force is recommending for those issues that further study be conducted.

A. Enhancing Regulatory Authority

Early in its deliberations the Task Force endorsed the existing hospital rate-setting system, and established as a high priority goal the preservation of that system.

Integral to the continuation of our system is the retention of the Medicare waiver, which is the mechanism whereby the federal Medicare Program is authorized to pay for hospital services according to rates set by Maryland's Health Services Cost Review Commission (HSCRC). The waiver is necessary for the preservation of a payment system that approves one rate that applies to all payers for hospital services.

This "all-payer" system provides an element of equity in Maryland that does not exist in many other states. Because all payers pay the same rates, there is no incentive for hospitals to favor one class of patients over another. Because all payers contribute to the reasonable costs of uncompensated care, there is no incentive to deny needed care because the patient has no means to pay.

The Task Force endorses the present system for an additional reason - the excellent performance of Maryland hospitals in reducing costs under that system. Since a federal waiver was first granted in 1977, Maryland has consistently "outperformed" the rest of the nation in terms of the rate of increase in hospital costs. Had the costs per admission and number of admissions increased in Maryland as they increased nationally since 1977, hospital costs would have been $950 million higher in Maryland. A significant portion of those savings have accrued to the federal government, as the federal Medicare and Medicaid Programs finance over 47% of hospital inpatient care in Maryland.

While the Task Force recognizes the strong performance of Maryland hospitals and the current regulatory system, it also finds that the political and fiscal environment is changing. It may be necessary to perform even better in the future in order to preserve the all payer rate-setting system and to assure that needed care is affordable for all citizens. Therefore, the Task Force makes the following recommendations for strengthening regulatory authority:

Recommendation 1: In reviewing rates, the HSCRC should have the clear authority to consider the efficiency and effectiveness of hospitals. (statutory change)

Recommendation 2: In determining whether a hospital is efficient and effective, the HSCRC should have clear authority to take objective standards of performance into consideration. (statutory change)

Recommendation 3: The HSCRC should have clear authority to consider objective standards in approving rates in a diagnosis-based rate system. (statutory change)

Recommendation 4: **The HSCRC should be authorized to establish annually a total affordability constraint on all hospital net patient service revenues other than private ambulatory services revenues. (statutory change)**

Recommendation 5: **The HSCRC should have the authority to set rates for all services offered by or through a hospital to its patients. (statutory change)**

Recommendation 6: **The HSCRC should have the authority to set rates for hospital ancillary departments which include the costs of hospital based ancillary physicians, regardless of the contractual arrangement between the physician and the hospital. Because there currently are impediments to implementing this recommendation for all payers, greater responsibility should be assumed by hospital boards to protect consumer interests. (statutory change)**

Recommendation 7: **The HSCRC should be able to deregulate hospital services when appropriate by defining those types and classes of charges which may or may not be changed without the approval of the Commission. (statutory change)**

Recommendation 8: **The HSCRC payment system should provide greater incentives to decrease unnecessary admissions. (regulatory change)**

B. Increasing Utilization Controls

The Task Force finds that an effective cost containment program must address the problem of medically unnecessary or inappropriate care. Closely related to this problem is that of the extreme variations that have been found in physican practice patterns, indicating a lack of consensus in the medical community regarding appropriate treatment. Current regulatory authority has been less effective in controlling the

utilization of hospital services that it has been in controlling the cost of those services.

The Task Force proposes a series of utilization controls to identify inappropriate care, and to educate the health care providers as to the variations in patterns of practice. The proposals are designed to reduce the volume of services utilized, and thereby reduce total health care costs. The Task Force makes the following recommendations to better control utilization of services:

Recommendation 9: There should be an effective utilization review program applicable to all hospital patients, including a second surgical opinion program. (statutory change)

Recommendation 10: Population-based utilization data identifying variations from area to area in physician practice patterns should be analyzed and published by the Department of Health and Mental Hygiene. (no change in authority)

Recommendation 11: The HSCRC should have the authority to collect and utilize information indentifying practice patterns of individual physicians, including patterns of practice across different hospitals. Names of individual physicians should not be subject to public disclosure. (statutory change)

Recommendation 12: The HRPC should have the authority to require compliance with requests for information required to develop and implement the State Health Plan, including appropriate sanctions for noncompliance. (statutory change)

Recommendation 13: Enrollment in health maintenance organizations should be promoted and encouraged. (no change in authority)

C. Health Insurance Strategies

The Task Force finds that rising health care costs have been reflected in escalating health insurance rates, and that those increased rates are a growing financial burden for employers, labor unions, and individual consumers. The proposals found elsewhere in the report should reduce total health care costs, and therefore should decrease health insurance expenses for health insurers, employers, and individuals. However, the Task Force makes several recommendations to specifically address rising health insurance costs. These are as follows:

Recommendation 14: Mandated insurance benefit laws should be reviewed to determine which, if any, should be repealed. Future enactment of mandated benefit laws should consider their impact on insurance costs, and on competition in the health insurance industry. (no change in authority)

Recommendation 15: The Insurance Commission should require three preconditions to the approval of any health insurance policy that designates low cost hospitals. These conditions are:

1. That the plan compare hospitals on a regional rather than a statewide basis when determining which hospitals are to be designated as low cost;

2. That the reasonable cost of uncompensated care, as determined by the HSCRC be excluded when hospitals are compared to identify low cost hospitals; and

3. That reasonable medical education costs, as determined by the HSCRC be excluded when hospitals are compared. (statutory change)

Recommendation 16: The Insurance Commissioner should publish a consumer guide to health insurance rates for comparable plans. (no change in authority)

Recommendation 17: Provider membership on the governing boards of non-profit health service insurance plans, specifically Blue Cross and Blue Shield plans, should be limited to a maximum of 25% of any board. (statutory change)

D. Reducing Excess Capacity

The Task Force finds that there is currently an excess of inpatient hospital beds in Maryland. It also finds that a variety of factors are contributing to a change in utilization patterns, with the result that excess inpatient capacity is likely to grow to thousands of beds within the next few years.

The Task Force has also determined that excess capacity in the health care system generates significant unnecessary costs, and that an effective cost containment program must include strategies for reducing that excess.

The Task Force proposes a number of actions to reduce excess capacity. The recommendations are designed to hold the system as is until needed changes are made; to identify excess beds and services in the system; to provide incentives and disincentives for hospitals to voluntarily reduce capacity; and finally to provide a regulatory authority to eliminate excess beds and services should voluntary efforts be insufficient.

The recommendations for removing excess capacity are as follows:

Recommendation 18: An immediate moratorium on all Certificate of Need applications, including new applications and docketed applications for which no decision has been made, should be established by emergency legislation. The moratorium should exempt applications addressing emergency circumstances that pose a threat to public health, and should expire on October 1, 1985. (statutory change)

Recommendation 19: Upon recommendation of either the Health Resources Planning Commission or the Health Services Cost Review Commission, the Governor

should have authority to suspend review of new and docketed but undecided Certificate of Need applications. Such suspensions shall be for specified periods of time and for specified classes of projects. Applications addressing emergency circumstances that pose a threat to public health should be exempted. (statutory change)

Recommendation 20: The HRPC should conduct an institution-specific study and develop an institution-specific plan for Maryland regarding excess hospital capacity. The initial plan should be completed by July 1, 1985 and appropriate regulations derived from that plan promulgated as soon thereafter as practicable. The HSCRC should consider the plan in its rate-setting process. (no change in authority)

Recommendation 21: A program to strengthen incentives and disincentives that encourage hospitals to voluntarily consolidate, convert, or close should be created. (statutory change)

Recommendation 22: The HSCRC should provide new financial incentives for mergers and consolidations that reduce excess capacity and increase the efficiency of the hospital system. (no change in authority)

Recommendation 23: Exempt closures, consolidations, conversions to non-health related uses, and reductions in licensed bed capacity, from Certificate of Need review unless the HRPC determines that review is in the public interest. (statutory change)

Recommendation 24: Initiate a process to find alternative uses for hospital buildings, portions of buildings, or sites no longer needed for acute care. (no change in authority)

Recommendation 25: A special program should be established to assist displaced employees. (no change in authority)

Recommendation 26: A special program should be established to protect outstanding long term indebtedness. (statutory change)

Recommendation 27: The Secretary of the Department of Health and Mental Hygiene should have the authority to "decertify" beds and/or services when excess capacity has been identified. The Secretary's authority may be invoked only upon petition by the HSCRC or the HRPC. (statutory change)

Recommendation 28: A Certificate of Need should be required for acquisition of major medical equipment by physicians or ambulatory care facilities. (statutory change)

Recommendation 29: Federal health planning legislation should be revised to allow for the inclusion of federal hospitals in the state planning process. (federal statutory change)

Recommendation 30: The Health Resources Planning Commission should have the authority to appeal Circuit Court decisions that reverses Planning Commission decisions. (statutory change)

E. Issues for Further Study

The Task Force considered a number of other issues that effect health care cost increases. Either because of insufficient information or because of time limitations recommendations were not developed to address these issues. However, the Task Force is recommending that these issues be studied further, and that proposals for action be

reported to the Governor by December 1, 1985.

The following are the recommendations for further study:

Recommendation 31: **A comprehensive review by the Department of Health and Mental Hygiene of the incentives needed to improve the financial health of the non-hospital sector should be made.**

Recommendation 32: **A study should be undertaken of the impact of insurance laws and policies on the availability and accessability of non-hospital based primary care.**

Recommendation 33: **A study should be undertaken to determine the extent to which graduate medical education should be financed by charges to patients, and to recommend specific reimbursement methods if this approach is continued.**

Recommendation 34: **A study should be made of ways to improve coordination and accountability of the various health regulatory agencies in Maryland, including the HSCRC and HRPC. The study should examine possible alternatives for modifying the structure of existing authorities to improve the states' ability to control health care costs.**

Recommendation 35: **A study should be done to determine the changes in law, regulation or policy that are necessary to permit health care professionals to make rational and ethical decisions in the care and treatment of hopelessly ill patients.**

Recommendation 36: **The Task Force recognizes the significant role that the cost of medical malpractice insurance has played in the escalation of health care costs, and supports the efforts of the Governor's Commission on Health Care Providers' Professional Liability Insurance to develop proposals for constraining the growth of those costs.**

IV. Conclusion

The Task Force concludes that if implemented these recommendations would work together to reduce unnecessary costs, or costs resulting from inefficient operation, throughout the entire health care system. While each recommendation would be effective in reducing the rate of increase in health care spending, the proposals in this report would have maximum impact only if all components of the health care system - including capacity, cost and utilization - are addressed. This "package" of interrelated recommendations is intended to address the health cost problem from this system-wide perspective.

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Task Force Report

I. WORK OF THE TASK FORCE

A. Governor's Charge

The Task Force on Health Care Cost Containment was formed by Governor Harry Hughes in August 1984 in response to growing public concern over health care costs. In his charge to the Task Force, the Governor recognized Maryland's excellent record of health cost containment, and the State's effective and progressive health regulatory system.[1] However, the Governor expressed concern that despite this record, the rate of health care cost escalation poses a serious threat to Maryland's citizens and its economy. Governor Hughes said that cost escalation threatens to undermine our ability to pay for other essential social needs.

The Governor also recognized the urgent need to constrain health cost increases expressed by Maryland management and labor groups concerned about the impact of those increases on business efficiency and productivity. Finally, the Governor addressed the need to protect the more vulnerable segments of the population from escalating health expenditures: the growing elderly population, the handicapped and disabled, and the economically disadvantaged.

The Task Force was asked to recommend ways to reduce health care costs by strengthening the existing regulatory system and by proposing new initiatives. More specifically, the Governor identified three major tasks: first, evaluate the hospital payment system, and recommend administrative and legislative changes necessary to enhance its performance; second, examine current "capacity" - the size of the hospital industry in Maryland - and recommend ways to improve the efficiency of the health care system by removing any excess; third, explore ways to control the cost of health insurance, consistent with Maryland's existing regulatory system. The Task Force was asked as well to look at ways in which the experience and expertise of State government

1 The Governor's charge letter is included as Appendix A to this report.

could be used to help business and labor to control health care costs.

B. Process of the Task Force

The Task Force first met on August 22, and met for the most part on a weekly basis from that date until December 6. A total of 15 public meetings were held, and included briefings and presentations from a variety of organizations with strong interests in health care cost containment.[2] Those presenting testimony before the Task Force were: the Maryland Hospital Association, the Health Services Cost Review Commission, the Health Resources Planning Commission, the Insurance Commissioner, Blue Cross of Maryland, Blue Shield of Maryland, Group Hospitalization, Inc., the Medical and Chirurgical Faculty, the Maryland Medical Assistance Program and the Health Facilities Association of Maryland.

The Task Force also heard presentations from nationally known experts on two issues: variations in physician practice patterns and preferred provider organizations. In addition, the Task Force commissioned a study of the impact of closing a hospital in Baltimore City on employees, which was completed by Dr. Steven Schwartz and Dr. Laura Morlock of Johns Hopkins University.

The Task Force conducted a public hearing in Annapolis on Tuesday, October 30. Written and oral testimony was received from many individuals and representatives of groups and organizations. Some of the proposals put forward during the public hearing are incorporated as recommendations in this report.

C. General Conclusions

In considering the issues surrounding health cost increases, the Task Force came to these general conclusions:

- Cost containment efforts should be directed toward eliminating inappropriate

2 A work plan outlining the issues discussed is included as Appendix B to this report.

services; needed services must continue to be available to all. No strategy to reduce costs that might deny access to needed care for any Maryland citizen should be pursued.

- The factors that lead to health care cost increases are many, varied, and deeply intertwined. Changes to one element in the health care system will impact several others. Therefore, a fully effective program of health care cost containment must attack the problem from several directions. For example, it is not enough to control the unit cost of services, or to reduce unnecessary days in the hospital. Efforts must also be made to control the volume of services that are not really needed in the course of delivering high quality medical care.
- Although this report focuses on containing hospital costs, the Task Force recognizes that non-hospital services also contribute to the increase in total health care costs. Public agencies must monitor the impact of these hospital cost containment initiatives to determine their effect on the growth of non-hospital services, as well as the cost impact of that growth.
- Physicians are the key actors in the health care system. Although physician charges for professional services are not a large part of total health care costs, nearly all health costs result from physician decisions to diagnose and treat. Several recommendations in this report are designed to enhance the ability of physicians to make those decisions effectively, efficiently, and appropriately.
- Past cost containment efforts in Maryland have worked in part due to unique cooperation among government regulators, employers, insurers, and industry trade associations. The health care industry in Maryland has consistently demonstrated an ability to put aside the interests of individual institutions when those interests conflict with what is best for the system as a whole. Continued cooperation is essential to the effectiveness of the cost containment measures presented in this report.

- Quality of health care has always been, and continues to be, of paramount concern in Maryland. The Task Force recognizes the high quality of care provided in this state, and believes that the proposals presented in this report should not adversely affect quality. First, reduced costs should increase financial access for patients to the services they need. Second, the recommendations are designed to establish appropriateness as the paramount criterion in rendering health care. The provision of appropriate care in an appropriate setting will enhance the overall quality of care. Third, if health expenditures are limited to those for appropriate care, the ability to finance needed services and equipment in the future will increase.
- Prevention of illness or injury improves the quality of life for all Maryland residents. Prevention also impacts significantly upon health care costs. When an illness or injury is prevented, the cost of any treatment that would have been required is avoided. The Task Force concluded that public and private prevention programs should be supported, and efforts made to increase their availability.
- Health care is a fundamental social need, and it is society's responsibility to assure access to quality care at a reasonable price for all those in need. The Task Force endorsed Maryland's regulatory system as an effective way to assure equity. The Task Force also concluded that a regulatory approach does not mean that competition is undesirable. Rather, regulation should be limited to what is necessary to assure access to affordable, quality care. Competition should be encouraged to the extent that it does not compromise the ability to meet the goals of equity, quality and affordability.

II. OVERVIEW OF THE HEALTH CARE COST PROBLEM

A. Introduction

Despite a decade or more of public and private sector initiatives to contain health care expenditures, the cost of medical services continues to increase at a rate that far exceeds the general rate of inflation for other goods and services. The adverse effects of this inflation has become a major shared concern of government, industry, business, labor, and the public at large. Increased health care costs limit access to care for large segments of Maryland's population - including the elderly and the economically disadvantaged. Such increases also reduce the productivity of Maryland businesses and hamper their ability to compete.

In addressing cost containment, Maryland begins with an established regulatory structure and a history of cooperative public and private sector efforts. There is every reason to believe that these efforts can and will continue. Indeed, they must, because recent changes in the political and economic climate require further strengthening of Maryland's regulatory system and the cooperation that has made it work. There are factors that contribute to inflation in health care spending that are only partially addressed by Maryland's existing system; new initiatives to recognize these elements are needed.

The Maryland system recognizes that affordability, quality, and access to care are all criteria by which the effectiveness of the health care delivery system must be judged. Quality and access must never be short-changed in an effort to control costs. However, the Task Force is fully persuaded that the State can reduce costs significantly without any sacrifice of quality and access.

B. Inflation in Health Care Spending

Inflation in health care spending in Maryland and the nation has been dramatic.

Total health care spending in the nation doubled every six years between 1965 and 1982. It rose from $42 billion in 1965 to $355 billion in 1983, an average annual rate of growth of almost 13 percent.[3] In 1965, health care expenditures amounted to $211 per person; by 1983 this increased to $1,459 per person.[4]

Comparisons between the health care sector and the economy as a whole in 1982 show a sharp contrast between the two (Figure 1, page 7). Most striking is that growth in expenditures in health care was at 12.7% while it was half that, or 6.4%, for the economy generally. In 1983, health care expenditures rose 16.3%, while the increase was 7.7% in the economy. The rate of increase in health care spending has been a particular concern of federal, state and local governments, which together finance over 42% of all health care spending. Faced with a fixed budget, health care inflation raises costs, lowers the number who can be served by existing health programs, and reduces the funds available for other social needs.

Similarly, people who live on fixed budgets are especially victimized by inflation in the cost of health care. Those who are more likely to need health care services -- the elderly, the poor, and the disabled -- can least afford to pay a larger and larger share of their income to doctors, hospitals, or nursing homes.

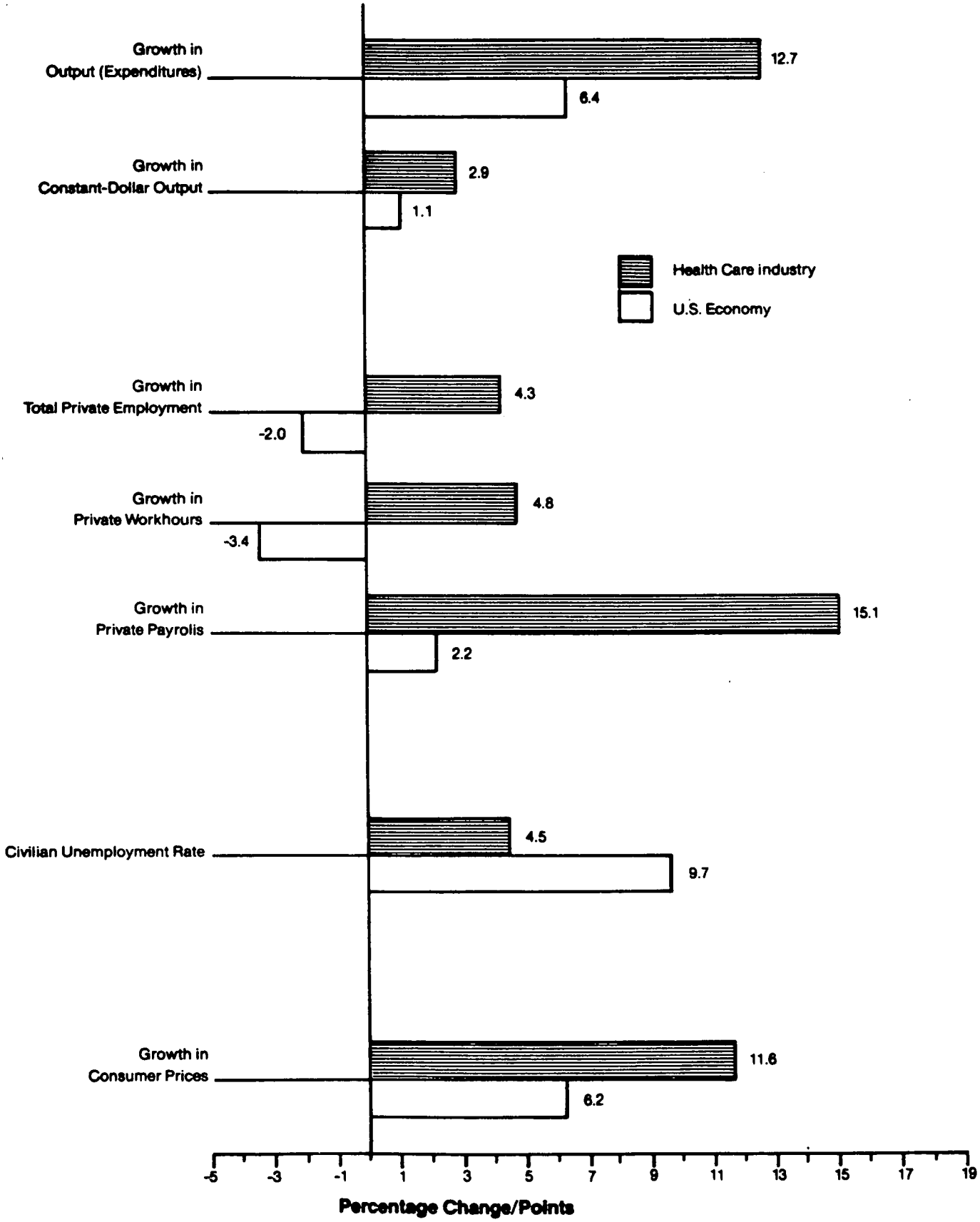
Hospital Expenditures

Hospital expenditures represent the largest and one of the most rapidly growing elements of total health care costs. In 1983, national expenditures for hospital care were $147.2 billion--an increase of 9% from 1982. Hospital care accounts for 47% of total personal health care spending. If the related cost of physician and other care provided in the hospital, before or after a hospitalization, is included, the proportion is much higher.

In Maryland, hospital costs account for almost half of all personal health care expenditures, despite the fact that Maryland's regulatory programs have kept the rate of

3. Robert Gibson, Katherine Levit, Helen Lazenby and Daniel Waldo, "National Health Expenditures, 1983", Health Care Financing Review 6:2 (Winter, 1984) (forthcoming).
4. Ibid.

Aspects of the Health Care Industry Compared to the Economy as a Whole, 1982



Source: Bureau of Data Management and Strategy, Health Care Financing Administration.

increase substantially below that of the nation.

- Over the past six years, Maryland's rate of increase in cost and charges per admission has averaged 4.7% and 7.7% respectively below the nation's.
- Since 1977, Maryland's cost per inpatient admission has dropped from 20.4% above the national average to 4.6% above the national average, while revenues per admission have gone from 16.3% above to 6.3% below the national average.

In 1983, these trends continued. Costs per day increased 12.9% for the nation, and only 8.8% in Maryland. Costs per admission were up 11.5% nationally, and almost half that in Maryland, or 6.3%. However, while Maryland's costs per admission and per day have consistently risen less rapidly than the national average, the aggregate rate of increase in total hospital patient revenue in Maryland still reflects a doubling of total expenditures between 1978 and 1983. (Figure 2, page 9)

Most significantly, net in-patient revenues in Maryland in 1983 increased at a faster rate than those in the nation. While the national revenue average was up 11.5%, Maryland's net patient revenue jumped 15.3% in 1983. Partial explanation for this phenomenon lies in the fact that Maryland has had little success in controlling the utilization of services (admission rates) and growth of new services.

Maryland's rate of hospital admissions is below the national average, but the difference is growing smaller:

- Maryland's rate of admissions per 1,000 population increased 0.8% in the first quarter of 1984, while in the U.S. the hospital admission rate declined 3.4%.
- In the second quarter of 1984, Maryland's admission rate declined 0.9%, but the national rate declined 3.8%.

FIGURE 2

MARYLAND ACUTE CARE HOSPITALS
GROSS PATIENT REVENUE
1977 - 1983

YEAR	GROSS PATIENT REVENUE	% INCREASE
1983	$2,040,538,100	15.9%
1982	$1,759,864,400	15.1%
1981	$1,528,782,548	13.2%
1980	$1,350,589,900	14.9%
1979	$1,175,088,600	15.6%
1978	$1,016,843,557	14.8%
1977	$ 885,544,535	-

Source: HSCRC Annual Disclosure Reports 1978 - 1984.

The length of time patients spend in Maryland hospitals has historically been higher than the national average. Maryland's length of stay was still more than half a day higher than the national average in the first quarter of 1984 (7.29 vs. 6.85). In the second quarter of 1984, the Maryland length of stay was 7.1 days versus 6.7 days nationally. The principal reason for this is substantially higher lengths of stay for Medicare patients in Maryland.

However, lengths of stay are dropping in Maryland, as are admission rates. These changes have exacerbated the growing excess of hospital beds in the State. In the first quarter of 1984, 54% of Maryland's acute hospitals were less than 80% full. By the second quarter of 1984, 75% of hospitals were below 80% occupancy. Excess bed capacity, which may soon reach 2,000 to 5,000 beds, increases hospital costs in two ways. First, certain fixed hospital costs must be absorbed regardless of the volume of care provided. Second, excess capacity adds pressure to increase admissions.

Physician Expenditures

While expenditures for physician services account for only about a fifth of all health care spending, the influence of physicians on total health care costs is far more pervasive than is reflected in this statistic. It is the physician who recommends inpatient care, the need for laboratory, radiology and other ancillary services, and a range of other health care services. Estimates are that the physician actually controls 70% or more of health care spending. In Maryland, this represents an expenditure of close to half a million dollars per practicing physician.

Physician control of expenditures represents a particularly thorny dilemma for public policy makers in light of the wide variations in practice patterns by physicians that have been documented in several states. Most of this variation does not appear to reflect differences in health status or medical need.[5] The Task Force heard preliminary

5. Philip Caper and Michael Zubkoff. "Managing Medical Costs Through Small Area Analysis" Business and Health, September, 1984.
John Wennberg and Alan Gottelson, "Variations in Medical Care Among Small

results of Maryland studies indicating that substantial differences in use rates for common surgical procedures exist within Maryland to at least the same degree as they do elsewhere. If cost control is ultimately linked to physician decisions, and these decisions vary so widely, it is extremely difficult to devise equitable and rational means to determine what care is appropriate and necessary, and to assure access to high quality care. The Task Force has resolved to begin to address this issue by proposing wider publication of this information so that physicians themselves, the public and policy makers can evaluate the situation.

Variation in physician practice patterns is likely to be an increasingly important issue in the years ahead when physician supply will far outstrip need. Based on standards developed by the Graduate Medical Education National Committee (GMENAC), Maryland was estimated to have a surplus of 118 physicians statewide in 1982, which is projected to increase by 2,237 in 1990. There is also a current and projected future imbalance between primary care physicians and specialists in the state. For example, while Maryland will have a shortage of 68 family/general practitioners and internal medicine physicians in 1990, the projected surplus of surgeons is 731. More surgeons tends to produce more surgery. Fewer general practitioners tends to mean less access to less expensive primary and preventive health care.

C. Factors Contributing to Rising Health Care Costs

Among the factors which contribute to rising health care costs, some, such as general inflation and aggregate population growth, influence health care as well as other markets. However, 42% of the increase in health care spending reflects the contribution of factors unique to the health services market. These include:

- Consumer Lack of Knowledge The complex nature of medical care takes the decision making out of the hands of most consumers. As a result, consumers

Areas", Scientific American, April, 1982.

defer to physicians either to make these decisions or, at a minimum, to advise and recommend treatment. Many consumers do not have the information they need to compare costs or consider alternative services, providers or delivery settings.

- o Physician Practices A physician's training, ethical commitments, and the manner in which he or she is paid reduces his or her stake in limiting care. Physicians are insulated from the cost of the hospital resources they consume on behalf of their patients. Because physician and hospital payments are usually separate, physicians have little or no incentive to use hospital resources in an efficient manner. As competition for patients grows with the "glut" of physicians, these problems will increase.
- o Insurance Health insurance has increased consumer access to needed health services and reduced the financial devastation associated with major illness. However, the growth of insurance has also increased health care spending by insulating consumers from the financial results of their decisions. This is particularly true for hospital services which are far more extensively insured than ambulatory care. (Approximately 91% of all hospital bills are currently paid for by third parties). Employers pay about 75% of the cost of insurance premiums. Consumers pay less than one third of the total health care bill directly, and less than 10 percent of the actual cost of hospital services. Health insurance benefits are not taxed, leading purchasers of insurance to prefer increased insurance coverage over other forms of income which are taxed. Only recently have traditional insurance plans begun to adopt some of the utilization control approaches that have been part of the success of prepaid group practices and HMOs.
- o Financing for Non-Hospital Care The American health care system generally includes strong incentives to use hospitals even when care in alternative settings

may be less expensive or more effective. Inadequate insurance coverage for ambulatory care accounts for widespread shortages in community based alternatives to care in the hospital. Expanded insurance coverage for outpatient surgery, home health care, and related services has recently helped to encourage use of these less expensive alternatives, while second opinion programs, pre-admission review and other utilization review programs have discouraged use of costly hospital care.

- o Medical Technology Advances in medical technology increases costs significantly. New technology increases costs by creating additional demand for services and adding equipment and operating costs to the system. While some new technologies reduce costs by eliminating inefficient services or procedures, the true cost and efficacy of most new medical technology is unevaluated and unknown until long after it is in use. Policy makers must strike an appropriate balance between the need to exploit technological advances to improve health, and the need to avoid unnecessary proliferation of technology. Programs to assess the effectiveness of medical technology must weigh the benefit of technological advances against their cost, so that technology of uncertain value does not detract from our ability to pay for other needed care.
- o Reimbursement Techniques Economists and policy analysts are virtually unanimous in their condemnation of cost-based reimbursement for health care. This system was, until recently, the predominant method of hospital reimbursement nationwide. Hospitals paid on the basis of their historical costs have no incentive to contain spending. Although Medicare recently changed to a prospective reimbursement system, the cost based method is still used extensively by other payers. The ill effects of cost-based reimbursement can be suppressed in those states, such as Maryland, which operate all payer prospective rate setting programs. In Maryland, hospitals are paid under a prospectively

based system and are rewarded for being efficient and penalized for being inefficient. This approach has resulted in substantial benefits to the citizens of Maryland. For the reasons set out in the next section of this report, the Task Force believes that the prospective payment system for hospitals should be strengthened and enhanced to preserve these benefits.

III. IMPORTANCE OF MARYLAND PAYMENT SYSTEM

A. Introduction

Many of the forces that led to the broad consensus establishing the Maryland hospital rate setting system and the Health Services Cost Review Commission (HSCRC) in the early 1970s remain important today. These include: the desire to assure access to hospital care for all patients regardless of their ability to pay, the importance of maintaining equity and reasonableness in payment by recognizing the legitimate financial requirements of hospitals, and fear that imposition of a Federal solution to hospital cost increases would not best reflect Maryland's needs.

Since 1977, the Maryland hospital payment system has featured a waiver of federal Medicare reimbursement methods that has contributed significantly to the success of the state's hospital cost containment program. The waiver permits Maryland's program to set a single payment rate for hospital care for all payers - Medicare, Medicaid, Blue Cross, private insurance carriers, and individual patients. This section of the report discusses the implications for the Maryland regulatory system of the waiver.

The significant reductions in hospital costs resulting from the Maryland all payer system have demonstrated that a state initiated approach to the problem of hospital cost containment can be effective. Had the cost per admission and the number of admissions increased in Maryland at the national rate since 1976, hospital costs would have been $950 million higher in Maryland. The Task Force supports the approach adopted by the Maryland General Assembly in 1971, and the Congress in 1972, that a state system operating within national standards can achieve substantial results.

Notwithstanding Maryland's past record, hospital costs continue to be a serious problem facing many Marylanders. The Governor convened this Task Force to examine Maryland's system and to propose changes that will enhance its ability to control costs for all citizens. The Task Force is aware that unless a statewide approach to cost

control for all payers is effective, many groups will be forced to seek individual solutions that may not be in the best interests of all.

The Task Force concluded early in its deliberations that preservation of the Maryland all payer hospital payment system, and the federal Medicare waiver that has been a part of that system, is of the utmost importance. While the Task Force's recommendations are targeted at many different components of the problem (including excess capacity, unnecessary utilization, divergent practice patterns, and efficiency standards), they are also designed to help assure continuation of the waiver.

B. Value of the All Payer System

1. Strong Incentives to Reduce Cost

   Maryland's hospital rate setting program gives hospitals incentives to reduce total costs by reducing unit costs and unnecessary services. All purchasers of hospital care share in the benefits of these incentives. At the same time, hospitals are barred from shifting costs. The Task Force believes these regulatory incentives and disincentives should be increased and strengthened, in part by introducing more objective standards of performance.

2. Universal Access to Care

   The Maryland rate setting system includes reasonable bad debt/free care expenses in the definition of hospital financial requirements, and allows for reimbursement of these expenses in hospital rates. More than 300,000 Marylanders are estimated to have no health insurance. When they require hospital services, and are unable to pay all or part of their bill, it becomes a bad debt for the hospital. Under the Maryland system, the costs of reasonable bad debt and charity care are shared by all payers. Because hospitals recover the same reimbursement from Medicaid and Medicare patients as from those with private insurance, poor and elderly patients are neither refused care nor

relegated to public hospitals. As a result, Maryland does not have a public charity hospital system as many other states must, where poor patients are often "dumped" because of their inability to pay.

3. Hospital - Specific Review

Under the Maryland system, hospital costs are reviewed and rates are approved on an individual, hospital by hospital basis. This allows for consideration of factors unique to particular hospitals, and brings an aspect of fairness to the system that cannot be achieved in a national payment system.

4. Consistency of Incentives and Payment Methods

Maryland hospitals have a uniform set of incentives and payment methods for all payers. As a result, hospitals may respond quickly to incentives such as those to reduce unnecessary lengths of stay or laboratory testing, because these incentives are uniform across all payers. In other states, hospitals find that individual payers exert varying and, at times, conflicting pressures to change, creating inefficiency and disruption.

5. Flexibility and Predictability for Hospitals

The all payer prospective rate setting system establishes reasonable hospital rates and for the most part allows hospitals to manage their revenue as they see fit within the overall constraint. Similarly, the methods used by the HSCRC to establish reasonableness and adjust rates are understood by the hospitals, so they may plan and operate in a predictable financial environment.

6. Equitable Apportionment of Costs and Payment Obligations.

Discounts are only awarded to payers who offer demonstrated cost savings to hospitals. Hospital patients in Maryland do not subsidize costs shifted between or among their own insurer and other payers. Payer obligations are distributed through a single accounting and reporting system on the basis of service utilization.

7. Collection of Sophisticated Data and Other Relevant Information

Maryland has led the nation in the development of a statewide hospital data base. Since 1977, the Maryland rate setting system has been receiving detailed demographic, clinical and financial data on all discharges from Maryland hospitals, and has made those data available to the public. The availability and accuracy of this information has enabled the HSCRC to develop sophisticated systems of hospital reimbursement, created the potential for more accurate health planning, and permitted the conduct of important health services research.

The Medicare waiver that is at the heart of the Maryland all payer rate setting system is only a means, and not an end. Yet, if it is lost, the Maryland hospital system, and Maryland's citizens, will lose many of these advantages. Loss of the waiver would mean disruption of the equity of Maryland's all payer system and the imposition of a national system which, among other things, severly penalizes inner city and non-teaching community hospitals. The national system will compare Maryland hospitals with hospitals in substantially dissimilar states. The issue is not whether Maryland as a whole will receive more or less money under the waiver. Rather, given the constraints on funds available for health care, the issue is whether a more equitable and reasonable distribution can be achieved by a national system that is unable to make appropriate distinctions between individual institutions than by a system designed specifically for the 54 acute care hospitals in Maryland. The Task Force believes the Maryland all payer system is better, and endorses the steps necessary to continue it.

C. Challenge to the All Payer System

In 1983, Congress adopted the most sweeping change in the Medicare program since its inception: the Prospective Payment System (PPS). The effects of the 1983

amendments on the Maryland waiver are several. First, the basis for comparison between Maryland and the nation has changed substantially. In the past, Maryland's increases in cost per admission were compared to a national standard based on retrospective, cost-based reimbursement methods. Under that test, Maryland hospitals have performed well. However, just as Maryland's prospective hospital reimbursement system has controlled costs, so can we expect the new federal prospective payment system to reduce Medicare expenditures, at least in terms of revenues per admission. Consequently, the national standards to which Maryland's system will be compared in the future may be substantially harder to "beat".

The second change in the 1983 federal law that affects Maryland will come from Congressionally mandated studies to reexamine and modify the system to reduce Medicare expenditures. These modifications may include a reduction in an adjustment for medical education costs, a change in the method of reimbursing capital from the current method of "passing through" the costs of capital, and other technical changes that could significantly reduce national Medicare expenditures and therefore affect Maryland's ability to keep its waiver.

Finally, the 1983 amendments to the Social Security Act added new provisions relating to retention of waivers. Maryland's waiver was granted under section 1814(b) of the Social Security Act. The new waiver section, 1886(c), establishes different conditions for obtaining and retaining a waiver. Federal regulations have not yet been issued under section 1886(c), so there is considerable confusion about whether or not an 1814(b) waiver will be affected by the new rules. Indications are that the new waiver test will not be based solely on a rate of increase in hospital costs, but will also compare aggregate hospital payments under the federal system to those payments under a waiver.

The Task Force believes that Maryland's waiver can continue under the conditions set forth in section 1814(b). However, because retention of the waiver is of critical importance to Maryland, it has recommended several significant changes in the hospital

rate setting system that will enhance the State's ability to meet any reasonable performance standard.

Despite Maryland's best efforts to pass a waiver test, it is possible that the waiver may be lost for reasons other than performance. Those opposed to a regulatory approach to cost containment have tried to eliminate state all payer waivers for years. Despite the excellent record of cost containment by the four waivered states, including Maryland, waiver critics may prevail.

This Task Force, representing a broad spectrum of business, labor, hospital, and legislative interests, has reached consensus on a series of recommendations which, if adopted, will give Maryland the tools necessary to meet future waiver tests. While these recommendations cannot guarantee protection from efforts to remove the waiver that are unrelated to performance, they demonstrate the resolve of all components of the Maryland health care system to take the steps necessary to preserve the all payer rate setting system.

IV. TASK FORCE RECOMMENDATIONS

The Task Force believes that each recommendation in this report would, by itself, be effective in reducing health cost increases. However, the Task Force appreciates the fact that the health care system is a "seamless web"; changes cannot be made in one part of the system without compensatory changes occurring throughout the remainder. Therefore, it is important to view the Task Force's recommendations as an interconnected whole, a package of recommendations.

In this section, the Task Force presents its recommendations in separate categories -- enhancing regulatory cost control authority, increasing utilization controls, strengthening health insurance strategies, and reducing excess capacity. These categories are only an organizational scheme. While each set of proposed changes represents a significant step toward constraining cost increases, no set addresses all of the problems of controlling costs while maintaining an equitable health care system. These proposals can have maximum cost containment effect only if capacity, cost and utilization are all addressed.

A. Enhancing Regulatory Authority for Cost Control

As indicated in the preceeding sections of this report, the political and fiscal environment is changing rapidly. The strong past performance of Maryland hospitals and Maryland's regulatory system may no longer be sufficient to preserve the all payer rate-setting system. Growing concern by business, labor and public leaders about the escalating cost of health care suggests the need for new control measures.

The recommendations in this section are designed to enhance the State's ability to control costs associated with hospital care. Proposals are presented to increase the effectiveness of Maryland's hospital rate setting program. Further, the Task Force expects that implementation of these recommendations will enable Maryland to realize

an increased dollar flow into the non-hospital sector of the health economy as well as an overall reduction in the rate of increase for health care expenditures.

Recommendation 1: **In reviewing rates, the HSCRC should have the clear authority to consider the efficiency and effectiveness of hospitals.**

Implementation Steps: Amend HSCRC statute

Discussion: The Task Force endorses the principles that the efficiency and effectiveness of a hospital should be considered by the HSCRC in approving rates, and that only those hospitals that operate efficiently and effectively should be assured rates to guarantee solvency.

The law now requires the HSCRC to set rates that will permit a hospital to provide, on a solvent basis, effective and efficient service that is in the public interest. The HSCRC has historically interpreted this to mean that there is no legal requirement that the solvency of hospitals be guaranteed in all circumstances. The Task Force agrees with this interpretation. Hospitals must operate efficiently and effectively. The State cannot afford to support an inefficiently and under-utilized health care system.

Recommendation 2: In determining whether a hospital is efficient and effective, the HSCRC should have clear authority to take objective standards of performance into consideration.

Implementation Steps:

- o Amend HSCRC statute
- o Develop and promulgate regulations regarding the standards to be considered and the circumstances under which such standards will be applied.

Discussion: This recommendation complements Recommendation 1 and is intended to clarify the HSCRC's authority to consider objective standards of performance in approving rates. "Efficiency" is related to the cost of or charges for hospital services,

while "effectiveness" relates to the need for those services. Among other reasonable objective standards, the Task Force finds that the HSCRC should be able to consider prevailing costs and charges at comparable hospitals, the standards set forth in the State Health Plan, provisions of the institution-specific plan regarding excess capacity (See Recommendation 18), and findings of authorized utilization review bodies, such as the Professional Review Organization (PRO).

Recommendation 3: The HSCRC should have clear authority to consider objective standards in approving rates in a diagnosis-based rate system.

Implementation Steps:

- o Amend HSCRC statute
- o Develop and promulgate standards

Discussion: This recommendation complements Recommendations 1 and 2. The HSCRC per discharge rate system, known as the Guaranteed Inpatient Revenue System (GIR), rewards hospitals for reducing unnecessary lengths of stay and diagnostic tests. It does so by comparing the hospital's performance in the current year with its performance in a selected base year, adjusted for inflation and the types of cases treated. Hospitals not judged high cost are allowed to keep the savings they achieve through greater efficiency.

This design was entirely appropriate in the early years of rate regulation when the goal was to limit the rate of increase in hospital costs. The GIR accomplished this by limiting growth per case to inflation plus 1%, at a time when the increase nationally was inflation plus 3 or 4%. However, the HSCRC should now have the authority to update the comparisons and to introduce a greater degree of objectivity into the performance standards.

The HSCRC needs the flexibility to develop those standards most appropriate and effective to accomplish its mandate. The proposed change would allow the HSCRC to measure a hospital's performance by reasonable objective standards, such as national

length of stay norms, or the prevailing costs or charges per case at comparable hospitals. The result would be that the HSCRC could grant very efficient hospitals rate relief by requiring less efficient hospitals to improve performance.

The Task Force has been told that performance standards are already being used by the HSCRC to bring down the rates of "high cost" hospitals. However, those arrangements are all voluntary, and are based primarily on the hospital's own cost experience. The change in the HSCRC law recommended would extend the HSCRC authority to consider objective standards of performance in the diagnosis-based rate setting process.

Recommendation 4: The HSCRC should be authorized to establish annually a total affordability constraint on all hospital net patient service revenues other than private ambulatory services revenues.

Implementation Steps: Statutory changes to HSCRC and HRPC statutes.

Discussion: The Task Force recommends that the HSCRC statute be amended to include a finding by the Legislature that, in the interest of promoting the general health and well-being of the citizens of Maryland, the HSCRC should be empowered to impose annually by regulation a total affordability constraint on hospital net patient service revenues to govern the share of total resources which may be consumed by the hospital industry. This constraint would not apply to uncompensated care.

In establishing this affordability constraint, the HSCRC should be empowered to consider changes in total personal income, per capita income, gross state product, migration patterns, the health care needs of the State, or other factors which it deems relevant. The HSCRC should be authorized to establish procedures to monitor hospital net patient service revenue levels (less private ambulatory services revenues) and to take actions pursuant to regulations to reduce those levels whenever necessary to bring them within the affordability constraint.

When the HSCRC determines that aggregate hospital revenues threaten the State's ability to stay within the total affordability constraint, it should be authorized to make a binding recommendation to the HRPC that any CON application that requires additional revenues is not financially feasible, the recommendation should be binding until such time as the HSCRC determines that the total affordability constraint is no longer threatened.

Among the additional actions the HSCRC should be authorized to take to reduce hospital patient service revenues are acceleration of spend-down agreements; revision of GIR savings percentages; imposition of a productivity offset to hospital rate increases; and revision of variable cost factors to restrain admission increases, particularly in areas with high per capita admission rates.

In exercising these powers, the HSCRC should have the flexibility to apply any or all of them to one or more hospitals, or class of hospitals, depending on what factors have, in the HSCRC's judgment, caused the net patient service revenue to exceed the total affordability constraint.

Recommendation 5: The HSCRC should have the authority to set rates for all services offered by or through a hospital to its patients.

Implementation Steps: Amend HSCRC statute.

Discussion: This recommendation addresses the issue of the HSCRC's current authority over the total costs of hospitals. At issue is what services may be, or must be, regulated. The Task Force agrees that it would not be possible for the HSCRC to control hospital rates effectively, or to take actions necessary to meet the Medicare waiver tests, if hospitals could "escape" regulation by contracting out essential hospital services. The Task Force urges that this problem be eliminated definitively by extending HSCRC's regulatory authority to hospital services as well as hospital costs.

Recommendation 6: **The HSCRC should have the authority to set rates for hospital ancillary departments which include the costs of hospital based ancillary physicians regardless of the contractual arrangement between the physician and the hospital. Because there currently are impediments to implementing this recommendation for all payers, greater responsibility should be assumed by hospital boards to protect consumer interests.**

Implementation steps: Statutory change and/or action by hospital boards of trustees.

Discussion: Certain hospital-based physicians, such as radiologists, pathologists, cardiologists and anesthesiologists, have contracts with hospitals which give these physicians the exclusive right to provide the professional (physician) component of these kinds of ancillary services to all hospital patients. The hospital thus grants a "monopoly" to those "ancillary" physicians, and neither the patient nor the patient's admitting physician may choose another physician to render these services. The consumer also has no say in the price charged for such services.

The HSCRC currently sets rates for these physician services only in cases where the physicians' remuneration flows through the hospital. The Task Force endorses the concept that the HSCRC should have the authority to set rates for ancillary services that include the costs of such physicians' services, regardless of the contractual arrangement between the physicians and the hospital. If implemented, the Task Force proposal would not require those physicians to become salaried employees, nor would it preclude the hospital from compensating them as it wishes. As with rates for all other hospital services, the HSCRC would establish reasonable rates and hospitals would be free to decide how the revenue is distributed within the overall limit.

However, Federal law may pose an obstacle to implementation of this recommendation through a change in state law. The extension of Maryland's waiver granted by the Health Care Financing Administration in July, 1983 stipulated that, for Medicare patients, the professional services of physicians provided to individual patients

in hospitals must be billed separately. In recognition of this, the Task Force agrees that, under the terms of the waiver, the concept of a single rate for ancillary departments that includes all physician costs could not be applied to Medicare patients. However, the problem needs a solution. Accordingly, the Task Force urges that each hospital's board of trustees, in granting exclusive rights to provide services to ancillary physicians, assume greater responsibility for assuring the public that the rates to be charged are reasonable.

Recommendation 7: The HSCRC should be able to deregulate hospital services when appropriate by defining those types and classes of charges which may or may not be changed without the approval of the Commission.

Implementation Steps: Statutory change

Discussion: The Task Force concludes that the HSCRC should have the authority to determine which hospital services should be regulated and which are not appropriate for regulation because the competitive market sufficiently controls the price of services. There appears to be no significant disagreement over the premise that every hospital service does not need to be price-regulated. For some services, such as home health care, price competition or sufficient payer control within the health care market may be sufficient to regulate price increases adequately. This change would allow the HSCRC to use its expertise to evaluate, in a timely manner, the need for regulating a service.

Recommendation 8: The HSCRC payment system should provide greater incentives to decrease unnecessary admissions.

Implementation Steps: Promulgation of regulations

Discussion: The HSCRC payment system should work toward the reduction of inappropriate admissions. This might be accomplished by reducing the variable cost factor for changes in admissions. The HSCRC has recently modified its regulations to

set the variable cost factor at 50% for all changes in patient volume. However, the Task Force believes further modifications may be desirable to reduce inappropriate utilization. As hospital utilization decreases, institutions will face strong pressure to increase admissions to fill empty beds. Implementation of this recommendation should be viewed in conjunction with the utilization control recommendations presented below.

B. Increasing Utilization Controls

The Task Force has concluded that the provision of medically unnecessary or inappropriate care and the provision of care in an economically inefficient manner have both been important elements in the spiralling of health care costs. The Task Force has considered research which shows wide variations in patterns of medical practice, which cannot be explained based on differences in the health of the population. While this research does not identify the "correct" rate for procedures within a given population, it does point to a general lack of consensus within the medical community as to the proper course of treatment for a large number of diagnoses.

To address these problems, the Task Force endorses the use of a variety of utilization controls designed to affect the behavior of providers and/or patients in terms of the quantity, quality and types of medical services used.

Three general types of utilization control have been examined. These are (1) utilization review, including second surgical opinion programs, (2) collection and publication of data on physician practice patterns, and (3) programs designed to channel people to the most efficient delivery setting.

"Utilization review" is the term applied to the process of establishing that health care services are medically necessary, appropriate and provided at the least expensive level consistent with a patient's condition. Absent this process, there is no assurance - other than the declaration of the rendering practitioner or institution - that a medical treatment, surgical procedure or diagnostic test is actually necessary, or that it must be

performed on an inpatient basis.

The collection and publication of data and other information regarding variations in practice patterns can also be effective in reducing utilization. Data on the practice of individual physicians across hospitals allows for the development of physician "profiles", so that differences between physicians' practices can be identified. Publication of these data in other states has brought about immediate and voluntary changes in physician behavior.

Finally, utilization can also be influenced by providing care in the most efficient delivery setting. Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are two approaches to influencing utilization of health care services considered by the Task Force.

Recommendation 9: There should be an effective utilization review program applicable to all hospital patients, including a second surgical opinion program.

Implementation Steps: Statutory change.

Discussion: Because the costs of unnecessary hospital use are borne to some extent by all payers, the Task Force finds that it is in the public interest for all unnecessary services and days to be controlled. It therefore recommends that some form of utilization review be performed for all hospital patients, regardless of the source of payment. The review should evaluate the need for each admission, for any ancillary services to be delivered, as well as the duration of a hospital stay.

The Task Force proposes implementation of utilization review for all patients through the establishment of a new condition for hospital licensure. The licensure standard should set up minimum criteria for a utilization review program, including the need for an independent, non-hospital affiliated, review agent. Utilization review by third party payers that meets the established standards would satisfy the licensure requirement for that payer's patients. Minimum criteria for a utilization review program

should include the following:

- o Preadmission review of elective admissions;
- o Admission review of emergency admissions;
- o Preauthorization of selected procedures if performed on an inpatient basis;
- o Preoperative day review and preauthorization; and
- o Discharge planning review

The Task Force also believes that unnecessary costs may be avoided with the use of mandatory second opinion programs. Second surgical opinion programs require that a patient receive a "second opinion" for selected procedures for which there is evidence of a high degree of variance in treatment patterns. These programs are aimed directly at consumers and individual providers of medical care, whereas other utilization controls focus on institutional providers.

The Task Force recommends that second surgical opinions for selected procedures be mandated in two ways. First, they should be made a required feature of hospital-based utilization review. Second, the Insurance Commissioner should require all regulated insurers to include second opinion programs in their policies.

The Task Force has received testimony indicating that second surgical opinion programs can result in substantial savings if they are based on use of an "objective" second opinion, not an opinion of a colleague of the first physician. There is little question that the goal of these programs, to reduce unnecessary surgery, is sound, and any negative impacts would likely be minimal.

Recommendation 10: Population-based utilization data identifying variations from area to area in physician practice patterns should be analyzed and published by the Department of Health and Mental Hygiene.

Implementation Steps: No statutory or regulatory change required.

Discussion: Significant changes in patterns of physician practice have resulted from the publication of data describing the high variability of those patterns between different areas of a state. These data show, for example, that the chances that men who reach age 85 have undergone a prostatectomy range from 15% to more than 60% in different hospital markets in Iowa. In Maine, analysis has revealed that by the time women reach 70 years of age the likelihood that they have undergone a hysterectomy is 20% in one hospital market while in another it is 70%. In Vermont, the probability that children will undergo tonsillectomy was shown to range from 8% to nearly 70% respectively in two separate hospital markets.

Preliminary studies in Maryland indicate similar findings. This proposal calls for the Department of Health and Mental Hygiene to analyze and publish such variation information for small areas in Maryland without identification of individual physicians. These data are now available to the Department, but have not been made generally available to educate physicians, hospital administrators, or hospital boards of trustees. Once these data are analyzed and understood, further regulatory action may not be necessary; prompt self-corrective action by physicians and hospitals in Maryland will likely follow.

Recommendation 11: The HSCRC should have the authority to collect and utilize information identifying practice patterns of individual physicians, including patterns of practice across different hospitals. Names of individual physicians should not be subject to public disclosure.

Implementation Steps: Statutory change

Discussion: At present, hospitals are not required to report data that would permit analysis of the practice patterns of individual physicians who practice in more than one hospital. The Task Force notes that federal Medicare law has recently been amended to require reporting and publication of these data for all participating Medicare physicians

for use by Professional Review Organizations. The Task Force believes such data will be of value to all Maryland practitioners, health planners and policy makers, and hospital medical boards. However, it does not believe such data should be made public in a way that will improperly focus public attention on particular physicians without careful analysis of the meaning of the data. Accordingly, the Task Force recommends that the HSCRC collect such data, that it be used by the HRPC and the Department of Health and Mental Hygiene for analysis and appropriate publication. Individual physicians should not be subject to public disclosure.

Recommendation 12: The HRPC should have the authority to require compliance with requests for information required to develop and implement the State Health Plan, including appropriate sanctions for noncompliance.

Implementation Steps: Statutory change

Discussion: Essential to any data reporting system such as that proposed in Recommendation 11 above, is the ability to require compliance. Currently, the only sanction available to the HRPC to enforce reporting requirements is to refuse to consider new Certificate of Need applications. This sanction has proven to be insufficient. Responsive and responsible health planning and regulation is absolutely dependent on the availability of reliable and complete data. Therefore, the Task Force finds that a stronger and more specific sanction for failure to supply the HRPC with required information is necessary.

Recommendation 13: Enrollment in health maintenance organizations should be promoted and encouraged.

Discussion: While many hospitals provide efficient care at low cost, the provision of care in an economically inefficient manner is a major contributor to the rise in health care costs. Health Maintenance Organizations (HMOs) are structured to provide incentives

for the efficient delivery of health care. A key element in an HMO is that providers are at risk if the cost of treatment exceeds pre-established norms. Therefore, a disincentive to provide unneeded care is present. The Task Force has determined that although no additional legislation to encourage HMO development in Maryland is needed, programs to promote the use of HMOs are required. The Task Force therefore recommends that the Maryland Medical Assistance Program pursue more extensive HMO participation among its recipients. In addition, state government should make special efforts to promote the benefits of HMO participation to state employees.

C. Health Insurance Strategies

The Task Force recognizes that rising health care costs are reflected in increasing health insurance rates paid by employers, unions, and individuals. The proposals presented in this report to control total health care costs, from the reduction of excess capacity to increased utilization controls, should result in decreased claims expenses for health insurers and employers. It is the judgment of the Task Force that savings to health insurers from health care cost containment should be directly reflected in the price of health insurance premiums. Indeed,it is imperative that the Insurance Commissioner assure that any such cost savings accrue to the benefit of employers, unions, and individuals.

The Task Force is concerned that there may be inadequate competition in the health insurance market in Maryland, and urges the Insurance Commissioner to discuss with private insurers who do not sell policies in this State the reasons for their failure to do so. The Task Force believes that Maryland's insurance costs might be reduced with broader competition in this area.

The following recommendations address more specifically several issues associated with the cost of health insurance in Maryland.

Recommendation 14: **Mandated insurance benefit laws should be reviewed to determine which, if any, should be repealed. Future enactment of mandated benefit laws should consider their impact on insurance costs, and on competition in the health insurance industry.**

Discussion: Third party payers and some employer-employee groups believe that Maryland's mandated benefit laws increase health insurance premiums, require private financing of what should be public programs, encourage employers to self-insure, and discourage commercial insurers from competing aggressively in Maryland. Providers generally assert that mandated benefit laws result in long term cost savings, provide significant societal benefits, and do not encourage self-insurance or discourage competition. The Task Force recognizes that present mandated benefit laws have been enacted separately, with little opportunity for a comprehensive analysis of their overall impact upon the costs of the health system. A review of each law from a comprehensive perspective may result in the identification of those laws which should be repealed in the public interest. Any future consideration of mandated benefits should address concerns related to costs and to competition in the health insurance industry.

Recommendation 15: **The Insurance Commissioner should require three preconditions to the approval of any health insurance policy that designates low cost hospitals. These conditions are:**

1. **That the plan compare hospitals on a regional rather than a statewide basis when determining which hospitals are to be designated as low cost;**
2. **That the reasonable cost of uncompensated care, as determined by the HSCRC, be excluded when hospitals are compared to identify low cost hospitals; and**
3. **That reasonable medical education costs, as determined by the HSCRC, be excluded when hospitals are compared.**

Implementation Steps: Statutory Change

inadequately informed concerning the relative merits of available insurance options. Such information should clarify areas of coverage, cost sharing, or out of pocket expenses, as well as premium prices. Because insurance plans vary considerably as to coverage, size of group and plan design, the Insurance Commissioner should design consumer guides based on comparable plans.

Recommendation 17: Provider membership on the governing boards of non-profit health service insurance plans, specifically Blue Cross and Blue Shield plans, should be limited to a maximum of 25% of any board.

Implementation Steps: Statutory amendment

Discussion: The relatively large number of provider representatives on the governing boards of some non-profit insurance plan raises questions as to whether providers may exert undue influence over the decisions of organizations that pay health care providers and institutions. Provider membership should be limited by law to avoid this problem. The specific proposal of the Task Force is to limit provider representation to no more than 25% of any board.

D. Reducing Excess Capacity

It has been recognized for some time that Maryland has an excess of hospital beds, most of which are concentrated in the more populated urban areas. Historically, the bed excess results from an era of public and private support for capital expansion in the health care system, shifts in population, and changing medical practice patterns. The Maryland health care delivery system is now experiencing a series of environmental changes that are dramatically altering hospital utilization patterns. For instance, during the first six months of 1984, Maryland hospitals saw these changes:

- a 7% drop in length of stay;
- a decrease in total patient days by 142,000; and

Discussion: Preferred Provider Organizations (PPO) are a relatively new strategy of employers and insurers to contain health care costs. A PPO establishes a "panel" of cost efficient hospitals, physicians, and other resources and provides incentives for patients to use them. Most PPOs realize the largest cost savings through stringent utilization review programs. Some PPOs, however, attempt to achieve cost savings by obtaining discounts from "preferred providers" and from patient direction to those less costly providers.

The Task Force endorses the position of the HSCRC with respect to discounts from hospitals for PPOs or any other organization. The HSCRC prohibits any discounts to PPOs except where they can be justified on a cost basis. With regard to patient direction, the Task Force is concerned about the potential impact of this practice on those hospitals that provide a large portion of tertiary care, those that provide high levels of uncompensated care, and on those that are teaching hospitals. Each could suffer significant losses of patient volume unless the portion of its costs resulting from the special care it provides is excluded when PPOs are organized.

The Task Force recommends that the Insurance Commissioner require insurers selecting providers for PPOs to (1) compare hospitals regionally, rather than state-wide, to minimize the impact of regional differentials, such as wage rates; (2) exclude the reasonable cost of uncompensated care, as determined by the HSCRC; and (3) exclude reasonable costs of medical education.

Recommendation 16: The Insurance Commissioner should publish a consumer guide to health insurance rates for comparable plans.

Implementation Steps: No statutory or regulatory change necessary.

Discussion: Public accountability will increase competition among insurers and provide an increased incentive to limit rate increases. The Task Force believes that consumers of health insurance, including both major employers and employee groups, are

- a fall in the average daily census by 800.

Several phenomena have contributed to these trends, including:

- growth in personal income and resulting improvement in the health of the population;
- increasing public participation in health promotion programs;
- changes in the administration of employee benefit plans;
- extension of the stringent Medicaid admission and utilization review activities to other payors;
- growth of alternatives to inpatient hospital care;
- changes in physician behavior in response to implementation of the GIR program in Maryland; and
- the federal prospective payment system nationally.

The results of these trends may increase Maryland's excess inpatient hospital capacity to at least several thousand beds within the next few years. Various estimates have placed the number of excess beds at between 2,000 and 5,000.

Of course these trends may change, and it is important to monitor the factors that might increase the need for services. However, the Task Force is persuaded that excess capacity generates unnecessary costs for the health care system in two ways. First, there are costs associated with maintaining unused capacity. Second, unused capacity creates an artificial demand that can lead to inappropriate or unnecessary care.

The true importance of removing excess capacity lies in long term costs averted. If excess capacity continues, some hospitals will face slow economic starvation unless they fill beds. If they succeed in filling the beds, the overall cost problem in the system will continue. Monies used to maintain excess capacity cannot be used in other programs important to the public health and well being of Marylanders.

The recommendations included in this section are designed to encourage voluntary consolidations, conversions, and closings, to reduce excess hospital capacity. The Task Force has concluded that voluntary downsizing should be encouraged through financial disincentives for inefficient resource use, and financial incentives to support

consolidation, conversion, reduction, or closure of hospitals. However, the Task Force finds that regulatory authority to remove beds or services should also be established in the event that voluntary efforts are insufficient. No state agency now has the authority to close a hospital, or even part of one. The need to eliminate excess capacity is so great that the Task Force believes the state must be able to act if the industry does not.

Before existing excess capacity is removed, the Task Force recommends a halt in growth in the entire health care system in the state to give all the relevant parties time to take stock of the situation.

Recommendation 18: **An immediate moratorium on all Certificate of Need applications, including new applications and docketed applications for which no decision has been made, should be established by emergency legislation. The moratorium should exempt applications addressing emergency circumstances that pose a threat to public health, and should expire on October 1, 1985.**

Implementation Steps: Statutory Change

Discussion: The Task Force recommends in this report a variety of cost containment proposals, many requiring statutory changes. This "package" of initiatives to control health costs, will establish broad policy direction for Maryland for years to come. To give the system time to develop, consider and absorb these changes as well as those in health care utilization patterns, the Task Force believes that a "freeze" of the system is necessary. If the Certificate of Need process continues before a cost containment program is in place, there is a danger that new projects, approved under the current State Health Plan will interfere with and run counter to the new cost containment program. The Task Force has concluded that all certificate of need applications must be affected by the moratorium to avoid inequitable treatment of any type of provider or project.

A statutory deferral of all CON applications maintains the status quo while the changing environment is assessed and needed modifications to the regulatory system are made. By July 1, 1985, new legislation to implement a cost containment program will likely be approved by the legislature. Therefore, the Task Force recommends that the moratorium continue until October 1, 1985 at which time the need to continue deferring applications may be re-evaluated.

Recommendation 19: **Upon recommendation of either the Health Resources Planning Commission or the Health Services Cost Review Commission, the Governor should have authority to suspend review of new and docketed but undecided Certificate of Need applications. Such suspensions shall be for specified periods of time, for specified classes of projects, and when a suspension is needed to promote and protect the public's access to quality health care at a reasonsble cost. Applications addressing emergency circumstances that pose a threat to public health should be exempted.**

Implementation Steps: Statutory change.

Discussion: It is extremely difficult for Maryland's Certificate of Need program to respond quickly to rapid changes in the health care system, such as the sudden recent drop in hospital utilization. There is no mechanism to stop the process in order to evaluate the system. This recommendation would permanently establish such a process for use when sudden rapid changes again require a time limited, well defined halt to capital expenditures or the development of new services.

The suspension process itself must contain safeguards to minimize the possibility of administrative abuse and protect due process for applicants. Suspensions would be limited to new applications and applications docketed. Where Certificates of Need have been issued, or decisions to award Certificates of Need have been made, no suspension would occur.

Recommendation 20: **The HRPC should conduct an institution-specific study and develop an institution-specific plan for Maryland regarding excess hospital capacity. The initial plan should be completed by July 1, 1985 and appropriate regulations derived from that plan promulgated as soon thereafter as practicable. The HSCRC should consider the plan in its rate-setting process (See Recommendation 2).**

Implementation Steps:

- o Contract, if necessary, for assistance in conducting the study.
- o Amend the Certificate of Need statute to require that an appropriately promulgated regulation derived from the institution-specific plan supercedes the State Health Plan where there is a conflict between the State Health Plan and the institution-specific plan.

Discussion:

The Task Force believes that a rational plan must be developed for identifying, on an institution-specific basis, where excess capacity both in beds and services exists, and alternatives for dealing with it. Only through the development of such a plan can a reasoned and orderly process of bed and service reduction occur. The plan should be a blueprint for an efficiently sized and effectively utilized health care system.

The Task Force believes that the HSCRC should have the specific authority to provide incentives and disincentives to achieve the plan's objectives, and has so recommended (See Recommendation 2). For instance, if a service is to be phased out within a year, rates for that service may be temporarily increased to compensate for gradually diminishing volumes. As closure is brought about, rates would be reduced accordingly.

Linking the institution specific plan to rate regulation provides an ability to tailor fiscal resources to the desired objectives. Further, it is a flexible mechanism so that adjustments can be made to accommodate specific and unique situations. This flexibility avoids the overkill or underachievement that may be present in other regulatory

solutions. To avoid any possible conflict between the need criteria of the State Health Plan and the institution specific plan, the planning law should establish that the later plan supercedes the former.

The fairness of the institution specific plan will be judged on the basis of its goals, criteria, and standards. The criteria and standards should address:

- o Physical plant characteristics;
- o Occupancies and admissions practices - in the aggregate and by major service;
- o Medical staff;
- o Institutional efficiency, including cost of providing services;
- o Demographic trends in the community;
- o Access to care and other community needs;
- o Financial strength; and
- o Special services and special expertise.

Even the ideal institution-specific plan can only marginally minimize the inevitable disruption that would result from closure or major reduction in services. The most that can be expected of such a plan when implemented is that the "right" facilities and services necessary for adequate health care stay open, and that the availability of quality services for all is not compromised. Because of these limitations, the Task Force is also recommending the development of a series of programs designed to minimize the disruption from capacity reduction in tandem with the institution-specific plan.

Recommendation 21: A program to strengthen incentives and disincentives that encourage hospitals to voluntarily consolidate, convert, or close should be created.

Implementation Steps: Statutory and regulatory changes.

Discussion: Financially unhealthy hospitals are expensive. Consolidations and conversions are viable approaches to improving the financial health of individual institutions and the system in general, and to increasing systemwide efficiency and

productivity. Conversion or consolidation can be more acceptable and less disruptive ways of removing excess capacity than closure.

The potential under the present rate-setting system for providing incentives for consolidations has not been thoroughly explored. Such incentives as have been offered in the past have not been sufficient to overcome the "natural" obstacles to mergers and conversions: institutional pride, community support, satisfaction with professional privileges, and need for jobs. Recommendations designed to strengthen the HSCRC's payment system, including the use of objective standards of performance, will encourage more serious consideration by hospitals of the desirability of consolidation or conversion. However, these incentives alone are not sufficient. Accordingly, the Task Force has a series of recommendations that together create a full "program" for voluntary downsizing of Maryland's hospital capacity.

With regard to mergers and consolidations, protection from antitrust prosecution must be provided. Statutory exemption from state antitrust laws should be enacted for hospital mergers and consolidations that contribute to reductions in capacity. In addition, as the following recommendations suggest, state agencies such as the HSCRC, the HRPC or both must have continuing supervision over the process of merger and consolidation.

Recommendation 22: The HSCRC should provide new financial incentives for mergers and consolidations that reduce excess capacity and increase the efficiency of the hospital system.

Discussion: Where mergers or consolidations are beneficial to the health care system, the HSCRC should establish new financial incentives to encourage them. For example, the Task Force believes that the HSCRC should provide the surviving institutions with rates sufficient to retire any outstanding debt service. In addition, the HSCRC could approve rates sufficient to cover the costs of retaining certain employees at the

surviving institutions for a reasonable specified period of time.

Recommendation 23: Exempt hospital closures, consolidations, conversions to non-health related uses, and reductions in licensed bed capacity, from Certificate of Need review unless the HRPC determines that review is in the public interest.

Implementation Steps: Statutory changes.

To streamline the process and lower the costs of reducing system capacity, the Task Force believes that hospitals planning to close, merge, convert, or reduce capacity should generally be exempt from the Certificate of Need process. Each facility planning such a move should be required to so notify the HRPC (as for example is now required for a change of ownership). The HRPC should have the discretion to decide that a CON review is in the public interest if, for example, it is inconsistent with the State Health Plan or the institution specific plan discussed in Recommendation 20. Exemptions for consolidation of two or more hospitals might be conditioned upon a short-term retention of employees who will be displaced by the consolidated facility, as outlined in the discussion in Recommendation 22.

Recommendation 24: Initiate a process to find alternative uses for hospital buildings, portions of buildings, or sites no longer needed for acute care.

The Task Force believes that the hospital community and the appropriate state agencies should work together to identify new uses for acute care hospital plants. The process should include consultation with the community, work with the HRPC when a new health care use is feasible and desired, and assistance from the Department of Economic and Community Development (DECD). Consideration should also be given to establishment of a Health Care Institution Redevelopment Corporation under the auspices of DECD.

Recommendation 25: A special program should be established to assist displaced employees.

If closure of units or facilities eventually occurs, it will be especially traumatic for an institution's employees - a problem not unique to the hospital industry. There are existing mechanisms to deal with the problems of displaced workers in general; Maryland's General Assembly recently created the Department of Employment and Training specifically for this purpose. Existing assistance programs should be extended to displaced hospital employees, complemented by additional efforts initiated by the hospital industry. At a minimum, programs designed to provide the following types of assistance should be made available to displaced hospital employees:

- o assistance with reemployment;
- o retraining programs; and
- o counseling services.

Assistance should also be made available to hospitals considering closure. Such assistance should include:

- o Provision of information, expertise and guidance based on other hospital closures.
- o Coordination of public and private agencies that have a role in hospital closure.
- o Assistance in public relations and communications aspects of hospital closure.

Recommendation 26: A special program should be established to protect outstanding long term indebtedness.

Implementation Steps: Statutory change

Discussion: The Task Force has concluded that the financial disruptions caused by closure of a hospital should be minimized by protecting the bonded indebtedness of the closing hospital. The Task Force finds that failure to meet net outstanding long term indebtedness could have a serious adverse effect on subsequent bond issues financing health care facilities, and possibly the State of Maryland itself. Obligations of the

Maryland Health and Higher Education Facilities Authority, the primary bonding source for Maryland hospitals, are a special concern. A program to insure the timely payment of outstanding long term bonded indebtedness is, therefore, necessary.

The Task Force recommends that, in the event of either voluntary or involuntary closure, outstanding bonds should be financed by spreading the debt among remaining hospitals. The process would work as follows. First, the Maryland Health and Higher Education Facilities Authority would determine the total number of dollars needed to continue payment of the bonded indebtedness of the closing hospital. That amount would then be communicated to the HSCRC, which would be authorized to include in every hospital's rate a portion of the amount needed to continue to pay the bond holders as though the original institution remained in existence. The Maryland Health and Higher Education Facilities Authority would then receive these monies directly from the institutions and disburse them in accordance with the original contractual obligation to the bond holders. Any monies remaining after payment of the bonds would be held by the Authority to continue payments in the future.

It should be reemphasized that this program would only be used for voluntary or involuntary closures that do not involve mergers or consolidations. Where mergers or consolidations are planned, the outstanding debt of any closing facility should be financed through rates of the surviving facilities, as is discussed in Recommendation 20.

Recommendation 27: The Secretary of the Department of Health and Mental Hygiene should have the authority to "decertify" beds and/or services when excess capacity has been identified. The Secretary's authority may be invoked only upon petition by the HSCRC or the HRPC.

Implementation Steps: Statutory amendment

Discussion:

The Task Force finds that new statutory authority is needed to require closure of

excess capacity, either beds or services. Such authority should only be exercised where voluntary actions, spurred by the incentives recommended by the Task Force, are insufficient. The due process rights of affected institutions must, of course, be protected in the decertification process, including appropriate notice and hearing procedures. The Task Force specifically discussed the proper location of this authority, and concluded that the Secretary of the Department of Health and Mental Hygiene was the appropriate office for that role. The Task Force recommends that the HSCRC and HRPC both be made necessary parties to any decertification procedure, and that the Secretary have the right to enforce decertification decisions by appeal of adverse court decisions, if necessary.

Recommendation 28: A Certificate of Need should be required for acquisition of major medical equipment by physicians or ambulatory care facilities.

Implementation Steps: Statutory change

Discussion: The current jurisdiction of the HRPC's Certificate of Need program extends only to major medical equipment acquired by or on behalf of a hospital. Ambulatory care facilities or private physicians may acquire and operate new equipment without obtaining approval from any public agency.

Major medical equipment can have a significant long term impact on the costs of health care. Not only are there large initial acquisition and installation costs, but there are also ongoing operating costs associated with such equipment. In addition, the need for new major medical equipment is often unclear to the public and to the medical community, so that the potential for inappropriate or unnecessary services is great. The present "loophole" in the jurisdiction of the HRPC has permitted significant growth in the availability and use of expensive technology without any opportunity for public scrutiny of the need for such growth. Therefore, it is important to the overall control of health costs that regulatory authority over the purchase of major medical equipment be

exercised regardless of the setting or the provider. The thresholds, in terms of dollar expenditures, beyond which approval is required should be the same for all providers.

Recommendation 29: Federal health planning legislation should be revised to allow for the inclusion of federal hospitals in the state planning process.

Implementation Steps: Federal statutory change

Discussion: To plan properly for a health care system that meets but does not exceed the needs of the population, it is necessary to take into account all services available to patients, including services available in federal hospitals. Federal law now exempts all federally owned hospitals from state Certificate of Need and planning programs. The Task Force believes that the federal exemption is no longer useful, and should be eliminated.

Recommendation 30: The Health Resources Planning Commission should have the authority to appeal Circuit Court decisions that reverse Planning Commission decisions.

Implementation Steps: Statutory change

Discussion: Under Maryland court decisions, an agency such as the Health Resources Planning Commission, which acts in a "quasi-judicial" capacity, may not appeal a decision by a Circuit Court reversing a Commission decision unless the General Assembly specifically authorizes such appeals. The HSCRC has specific statutory authority to appeal Circuit Court decisions. The HRPC has no such authority, and is vulnerable to Circuit Court reversals of its decisions without any opportunity for higher review. Inconsistent decisions in different circuits have resulted, and the HRPC is unable to enforce its decisions. In the absence of a statute permitting the agency to appeal such decisions, the rulings of the Circuit Court become the final interpretation of Maryland law in this area. The Task Force expects the HRPC to contribute to the State's efforts to control unnecessary costs, and believes it must have the right to appeal to protect its

decisions.

E. Issues for Further Study

The issues addressed in the following recommendations were considered at length by the Task Force and were determined to affect health cost increases significantly. For some of these matters, the Task Force concluded that the information available at this time is insufficient to form the basis for specific recommendations. For others, the Task Force simply did not have the time to give the issue adequate review. Therefore, the Task Force is recommending that these issues be studied further and the results reported to the Governor.

Recommendation 31: A comprehensive review by the Department of Health and Mental Hygiene of the incentives needed to improve the financial health of the non-hospital sector should be made.

Implementation Steps: Study submitted to the Governor by December 1, 1985.

Discussion: The promotion of incentives to stimulate development of non-hospital services is necessary to assure the success of proposals designed to reduce excess hospital capacity and costs. Incentives for expansion and growth in the hospital sector, most obviously access to capital markets, have not been available to community health centers or ambulatory facilities that cost less to operate but provide effective medical care.

Recommendation 32: A study should be undertaken of the impact of insurance laws and policies on the availability and accessibility of non-hospital based primary care.

Implementation Steps: The study should be completed and provided to the Governor by December 1, 1985.

Discussion: As a companion to the preceeding recommendation, this study should focus on the relationship of reimbursement policies to the growing oversupply and maldistribution of physicians. While in many medical sub-specialties the oversupply is considerable, there is a growing shortage of primary care physicians in many areas of the state. Sufficient information is not yet available upon which to base recommended actions, but the Task Force believes that inadequate access to primary care contributes to inappropriate expenditures for more expensive specialized medical care in physician offices and hospitals. Reimbursement levels of third party payers for services in community based or ambulatory facilities have not been sufficient to attract patients and physicians away from hospitals. Insurance programs, including Medicare and Medicaid, generally provide more complete coverage and higher reimbursement levels for hospital care than for non-hospital care. Therefore, the Task Force recommends that a study be initiated immediately to determine the extent to which present reimbursement policies that pay more for services delivered by specialists contribute to the problem. This study should include:

a. A review of insurance laws and reimbursement policies of payers in order to identify and change any practices that discourage primary care.
b. A review of insurance laws and payer policies with respect to non-physician providers, to determine if changes would increase access to primary care.
c. An examination of incentives that might be used to encourage physicians to establish primary care practices in underserved areas.

Recommendation 33: A study should be undertaken to determine the extent to which graduate medical education should be financed by charges to patients and to recommend specific reimbursement methods if this approach is continued.

Implementation Steps: The study should be completed and provided to the Governor by December 1, 1985.

Discussion: The issue of the financing of the costs of medical education is very complex, and involves both state and federal policy questions. The Task Force finds that a study of this issue should be conducted and that the study should include a review of the current financing system, alternatives for changing that system, as well as an examination of federal policy in this area and the likely impacts of that policy on Maryland. Further, the study should explore ways in which graduate medical education should be financed other than through patient charges.

Recommendation 34: A study should be made of ways to improve coordination and accountability of the various health regulatory agencies in Maryland, including the HSCRC and HRPC. The study should examine possible alternatives for modifying the structure of existing authorities to improve the State's ability to control health care costs.

Implementation Steps: Appointment of a Study Commission with a report to be completed by December 1, 1985.

Discussion: Although the issue of regulatory coordination and accountability was not directly part of the charge to the Task Force, it became apparent to the members that the cost containment proposals under consideration would require maximum cooperation among regulatory agencies. There was much discussion concerning improving the consistency and accountability of the regulatory decisions of the HSCRC and HRPC through restructuring the authorities of those independent commissions. The Task Force concluded that, while there is merit to these arguements, the issues involved are very complex and warrant further study. Therefore, a study of improving regulatory coordination and accountability is recommended, to be completed by December 1, 1985.

Recommendation 35: A study should be done to determine the changes in law, regulation or policy that are are necessary to permit health care professionals to make rational and

ethical decisions in the care and treatment of hopelessly ill patients.

Implementation Steps: The study should be completed and provided to the Governor by December 1, 1985.

Discussion: In recent years tremendous progress has been made in the development of advanced medical technology and procedures. While this progress has greatly enhanced the ability of physicians to restore health, it also raises difficult and complex questions with regard to keeping patients alive who have little or no hope of recovery. Clearly such issues primarily involve moral and ethical decisions on the part of patients, their families, and health care professionals. However, the provision of procedures that serve only to prolong the life of hopelessly ill patients is also relevant to the issue of health cost containment. A large portion of health care expenditures go toward the prolonged and often very costly procedures necessary to treat those who will not recover.

The Task Force believes that decisions regarding the continuation of treatment and procedures for the hopelessly ill are best left to the patient or the patient's representative, the patient's family, the health care professionals involved, and professional and ethical advisors such as are provided through hospital ethics committees. However, the Task Force also finds that it is important to protect against legal liability a rational and ethical decision-making process in which all options are fully considered by the patient, the family, and the treating physician. Therefore, the Task Force recommends that a study be done of the appropriate means of providing this protection.

Recommendation 36: The Task Force recognizes the significant role that the cost of medical malpractice insurance has played in the escalation of health care costs, and supports the efforts of the Governor's Commission on Health Care Providers' Professional Liability Insurance to develop proposals for constraining the growth of those costs.

Discussion: One of the factors contributing to the increase in health care costs is the growth of medical malpractice claims and the consequent increase in the costs of malpractice insurance.

The Task Force recognizes the significant effect that the liability exposure of physicians has had on the escalation of health care costs, and believes that this issue should be thoroughly examined. Since the Governor has formed a Commission on Health Care Providers' Professional Liability Insurance, the Task Force endorses the efforts of that Commission to find solutions to this problem.

APPENDIX A

HARRY HUGHES
GOVERNOR

STATE OF MARYLAND
EXECUTIVE DEPARTMENT
ANNAPOLIS, MARYLAND 21404

August 6, 1984

Dear _____:

Despite numerous public and private sector initiatives to contain health care expenditures, the cost of medical service continues to increase at a rate which far exceeds the general rate of inflation for other goods and services. Health care expenditures now account for more than 10 percent of the country's gross national product.

While Maryland has led the nation in the development of effective and progressive cost containment strategies, the current rate of health care cost escalation threatens to undermine our ability to fund other essential social needs, the productivity of business and, more important, the access of our citizens to affordable quality medical care. The pressure to reduce health care costs both nationally and in Maryland poses a number of perhaps unprecedented challenges to our health care system, in particular our hospital industry. In order to meet these challenges, we must strengthen our existing regulatory cost containment system and develop new initiatives to reduce health care costs.

Since containment of medical care costs is of tremendous importance to the citizens of Maryland and major public policy, I have decided to establish a Task Force on Health Care Cost Containment.

I am very pleased to appoint you to serve as a member of the Task Force. Mr. Eugene Feinblatt has agreed to serve as Chairman and he will be in contact with you shortly to make arrangements for the first meeting of the Task Force.

To the extent feasible, the Department of Health and Mental Hygiene shall furnish staff support to the Task Force. I am also directing the Department of Licensing and Regulation, the Health Resources Planning Commission and the Health Services Cost Review Commission to provide such additional staff support necessary to the completion of the functions of the Task Force.

I am requesting the Task Force to examine our hospital reimbursement system and recommend administrative and/or legislative changes which will enhance the performance of the State's hospital rate setting program and preserve Maryland's Medicare Waiver. I believe it is essential that Maryland retain its waiver. The Medicare waiver is an integral part, if not the foundation of the Health Services Cost Review Commission's (HSCRC) effort to contain hospital costs. Since 1976, Maryland's rate setting program has saved more than $1 billion in hospital costs for all payers while, at the same time, improving the access of Maryland citizens to quality health care. In examining our hospital reimbursement system, I believe the Task Force should carefully consider, among other relevant factors, the following issues:

- The need to revise the HSCRC statute to clarify its mandate to insure hospital solvency and its authority to determine methodologies for setting hospital rates;

- The current method of financing bad debt and charity care;

- The unique costs and current methods of financing medical education at teaching hospitals; and

- The findings of the HSCRC study comparing the performance of Maryland's hospital reimbursement system to the national Medicare Prospective payment system.

In addition, I am requesting the Task Force to examine the current capacity of Maryland's health care system, and to recommend administrative and/or legislative initiatives which will improve the efficiency of our health care system and reduce unnecessary capacity, particularly hospital beds. The Health Resources Planning Commission (HRPC) estimates that there are 800 to 1,000 excess hospital beds in the state, primarily in the Baltimore Metropolitan Area. Due to a decline in utilization as well as efforts to reduce lengths of stay at hospitals, I have been informed that the HRPC's estimates may be conservative. I believe the reduction of excess capacity is an essential element of our effort to contain overall health care costs and important to the long-term financial stability of our hospital industry. In examining measures to improve the efficiency of our health care system, the Task Force should consider, among other relevant factors, the following:

- The need for an institution specific capacity plan;

- The need to defer pending capital projects until an institution specific capacity plan is developed;

- The need to provide authority to regulatory agencies to reduce excess capacity such as bed decertification authority;

- Productive, alternative uses for excess hospital capacity;

- The distribution of existing hospital beds and the access of citizens to health care; and

- The need to regulate the acquisition of major medical technology by physicians.

Further, I am requesting the Task Force to examine and recommend initiatives designed to control the cost of employment-based and other forms of health insurance which complement Maryland's existing regulatory cost containment system. Over the last few years government has taken steps to reduce the cost of publicly financed health care programs for the poor and elderly. In many states these reductions have simply resulted in increased charges to Blue Cross and Blue Shield, commercial insurers and other private payers. In Maryland there fortunately is no incentive to shift costs because everyone pays essentially the same rate for a service under our all payer reimbursement system. Moreover, employers, employees and other individuals in Maryland have shared in the savings resulting from our hospital reimbursement system.

However, the cost of health insurance has risen dramatically with premiums increasing over 130 percent since the mid 1970s. The Chrysler Corporation estimates that the cost of providing its employees with health insurance had added $600 to the price of every new car. For many manufacturing firms health care is now the third highest single expenditure, surpassing retirement costs, energy costs, and outside services, and following only raw materials and direct compensation. Neither employers nor employees can continue to absorb health care cost increases of this magnitude.

In addition to strengthening our regulatory cost containment system and improving the efficiency of our health care providers, government, business and labor must work together to develop complementary strategies to reduce the cost of employment-based health care coverage. The Task Force should consider, among other relevant factors, ways in which the experience and expertise in state government could be utilized to assist business and labor to control health care costs. To the extent we are successful, we will improve the productivity and competitiveness of our existing industries and potentially create a climate which will enhance our efforts to attract new business to Maryland.

As the containment of health care costs is essential, I ask that the Task Force submit a report on its findings and recommendations by December 1, 1984.

In Maryland, we are fortunate to have a spirit of cooperation between government, business, labor and the health care industry. Over the years this cooperation has enabled the State to establish a new health planning system, a more effective nursing home reimbursement system and improve the fiscal stability of the Medicaid program. Perhaps nowhere, however, is this cooperation more in evidence than in the development of our unique all payer hospital reimbursement system. While these efforts were predicated on hard decisions and sacrifices, the affected interests worked together to develop equitable solutions to the problems confronting our health care system.

I appreciate your willingness to serve on this Task Force and believe that, working together, we will meet the challenges now facing our health care system.

Sincerely,

Harry Hughes

Governor

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Appendix B
TASK FORCE WORK PLAN

August 22

- o Introductory Meeting

Spetember 6

- o Deferral of Certificate of Need Applications
- o Briefings - Health Services Cost Review Commission, Health Resources Planning Commission

September 13

- o Deferral of Certificate of Need Applications
- o Briefings - Insurance Commission, Group Hospitalization

October 4

- o Excess Hospital Capacity

October 11

- o Strengthening HSCRC Authority

October 18

- o Variations in Physician Practice Patterns
- o Physician Reimbursement
- o Utilization Review
- o Health Maintenance Organizations
  Preferred Provider Organizations
- o Briefings - Blue Cross of Maryland, Blue Shield of Maryland, Medical and Chirurgical Faculty, Maryland Medical Assistance Program

October 23

- o Variations in Physician Practice Patterns
- o Preferred Provider Organizations

October 25

- o Strategies for Reducing Excess Capacity
- o Briefing - Health Facilities Association of Maryland

November 1

- o Meeting to Consider and Revise Report to Governor

November 8

- o Meeting to Consider and Revise Report to Governor

November 21

- Meeting to Consider and Revise Report to Governor

November 29

- Meeting to Consider and Revise Report to Governor

November 30

- Meeting to Consider and Revise Report to Governor

December 1

- Meeting to Consider and Revise Report to Governor

December 6

- Meeting to Consider and Revise Report to Governor